Patient-Centered Care for Underserved Populations: Best Practices

A Case Study of Cambridge Health Alliance

prepared for

The W. K. Kellogg Foundation

by

Larry Stepnick
Sharon Silow-Carroll

Economic and Social Research Institute

2100 M Street, N.W., Suite 605
Washington, DC 20037
www.esresearch.org

March 2006

Acknowledgements

The authors would like to thank the W. K. Kellogg Foundation for supporting this research. The W.K. Kellogg Foundation is a nonprofit organization whose mission is to apply knowledge to solve the problems of people. Its founder W.K. Kellogg, the cereal industry pioneer, established the Foundation in 1930. Since its beginning the Foundation has continuously focused on building the capacity of individuals, communities, and institutions to solve their own problems. "To help people help themselves through the practical application of knowledge and resources to improve their quality of life and that of future generations." For more information, see www.wkkf.org

We also thank Priscilla Dasse, Senior Vice President, Performance Improvement at Cambridge Health Alliance (CHA), who was instrumental in organizing the site visit, providing information, and offering valuable insights. We are grateful to David Bor, Linda Borodkin, Linda Cundiff, Laureen Gray, Rene Guerrier, Wendy Gutterson, Janet Marroquin, Mark McGovern, Lisa Montouri, Laura Nevill, Dr. David Osler, Claire Paras, Loretta Saint Louis, Dr. Ralph Upchurch, Alice Verhoeven, and Dr. Rachel Wheeler, and others at CHA who generously provided their time and perspectives during our site visit in July 2005.

About the Economic and Social Research Institute

The Economic and Social Research Institute (ESRI) is a nonprofit, non-partisan organization based in Washington, D.C that conducts research and policy analysis in health care and in the reform of social services. ESRI specializes in studies aimed at improving the way health care services are organized and delivered, making quality health care accessible and affordable, and enhancing the effectiveness of social programs. For more information, see www.esresearch.org.

About the Authors

Larry Stepnick, MBA, is vice president of The Severyn Group, a research, consulting, and communications firm that specializes in conducting qualitative and quantitative research, and writing and producing publications on a wide range of issues that span virtually all aspects of health care, including financing, management, delivery, and performance measurement. Mr. Stepnick can be contacted at severyngroup@msn.com.

Sharon Silow-Carroll, M.B.A., M.S.W. is Senior Vice President at ESRI. Ms. Silow-Carroll's areas of expertise include health care reform strategies and meeting the needs of vulnerable populations. Her recent projects include: assessing state efforts to stretch limited health care dollars; reviewing community-based programs to expand health coverage to low-income workers; and examining local initiatives to enhance access to oral health care. She is author of numerous reports and articles analyzing public and private sector initiatives aimed at enhancing access, containing costs, and improving quality of health care. Ms. Silow-Carroll can be contacted at silow@optonline.net.

Case Study: Cambridge Health Alliance

Summary: Best Practices in Patient-Centered Care (PCC)

Cambridge Health Alliance (CHA) is an academic public health care system and integrated delivery network that serves seven major communities with large low-income, immigrant populations north of Boston, MA. CHA is pursuing consumer/patient-centered care (PCC) for underserved populations in a variety of ways, through special initiatives as well as everyday operations.

Following are "best practice" strategies undertaken at CHA that exemplify or operationalize the core components of PCC. Many of these strategies can be replicated at other organizations, albeit with modifications or adaptations to meet specific circumstances and needs.

Create a Welcoming, Familiar Environment:

- Signs are written in the four languages most commonly spoken by patients.
- Artwork in facilities is tailored to the cultures served, purchased from local artists by a special committee.
- Staff go beyond the minimum to assist patients; e.g., walking them to destination when asked for directions.
- Staff wear buttons with greetings in languages spoken, and dress in ways that reflect their culture.

Respect Patients' Values and Expressed Needs:

- Provider-patient conversations are structured to elicit patients' issues, priorities, and concerns.
- Emergency rooms are run as "judgment-free zones."

Educate and Empower Patients:

- "Shared care plans" are developed jointly by chronic care patients and physicians to set health goals and monitor progress.
- Support groups and "group visits" are tailored to specific chronic diseases or ethnic groups.
- Educational materials are written at accessible literacy level, in multiple languages, and in print, software, and/or audio-based venues.

Promote Socio-cultural Competence:

- Clinic staff are largely bilingual.

- Interpreters are available 24/7 in 40 languages, with 40 fulltime interpreters and others available as-needed; interpreters become "cultural translators" and patient advocates.
- Volunteer health advisors (VHAs) from local communities educate patients and set appropriate patient expectations in a way that is consistent with their culture and literacy level.

Coordinate and Integrate Care, Ensure Smooth Transitions:

- Electronic information system informs providers about patients' health history and appropriate tests, and provides patients with post-visit summaries including diagnoses, medications, referrals, etc.
- VHAs help patients navigate system, conducting follow-up, arranging transportation, and accompanying patients when necessary.

Emphasize Physical Comfort and Emotional Support, Involve Family/Friends:

- ICU has 24-hour visiting hours, and family members may stay with patients in the emergency department (ED).
- Women with uncomplicated pregnancies have option to use home-like birthing center and family participation during birth.
- ER has standing orders for pain and fever management, reducing time to administer medication.
- "Doula" program provides informational, emotional, and physical support to socially isolated pregnant women.

Ensure Easy Access to Care:

- "One-stop shopping" facilitates access; e.g., nutrition and mental health screening and treatment were added to health center services.
- Women's health clinic has evening hours.
- ED uses "fast track" system to speed care for less urgent patients.
- Clinic accommodates teenage "walk ins" for family planning services.
- Clinic uses "open access," setting aside a portion of appointments for walk-ins, same-day access or appointments within 72 hours.

Conduct Extensive Community Outreach:

- CHA establishes partnerships with local government, school systems, housing agencies, businesses, and other community-based and not-for-profit organizations.
- Community Affairs Department conducts community-based programs including: case management; health promotion services; tobacco cessation programs; senior health programs; the volunteer health advisor (VHA) program; the zero disparities committee; multilingual interpreting, translation, and cultural competency training; HIV community services; family

planning, women's and adolescent health; women, infant, and children's (WIC) program; and health care for the homeless.

- CHA has been able to implement the above strategies only because a number of supportive structures and processes were in place. It is recommended that other health care organizations pursue and build up these supports in order to enhance PCC, particularly for underserved populations. Below are the key "ingredients" with some specific examples of how they are manifested at CHA:

Passionate, Committed Leadership

- Internal communications from the CEO emphasize commitment to serve a diverse customer base in a patient-centered way.
- Aggressive performance goals include improvement in patient satisfaction.
- Local units must develop concrete plans and goals for reaching PCC-related "alliance promises" pertaining to the "four I's": introduce, inform, initiate, and interact.

Committees Devoted to PCC (see full report for descriptions)

- Patient-Centeredness Steering Committee (PCSC).
- Patient/Family-Centeredness Nursing Council.
- Patient/Family Advisory Council.

Staff Recruitment and Development

- Applicants receive detailed information on CHA's mission and community-based, patient-centered approach in brochures, interviews, and counseling.
- New staff orientation includes understanding PCC; how to partner, interact, build relationships, and resolve conflicts with patients. Supplemented by a new one-day stand-alone seminar, and a variety of "mini workshops" on PCC conducted on a regular basis at staff meetings.
- Integrated Clerkship pilot program assigns third year medical students to "follow" individual patients through the year and thereby gain a deep understanding and appreciation for the patient and his or her preferences, values, challenges, and environment.

Rewards and Recognition

- New compensation structure for senior leaders (including vice presidents and directors) that ties compensation to performance on 10 indicators, two of which relate to PCC.
- Salary increases for physicians are tied to incentives, including patient satisfaction scores.
- Monthly "Promises Award" is given to one employee from each hospital campus and ambulatory site for providing outstanding service to patients.

- Individuals and units that have had particularly noteworthy successes are invited by the CEO or other senior leaders to give a presentation on their programs, so that these practices can be celebrated and replicated throughout the organization.

Longevity and "Counseling Out"

- Retention efforts promote staff longevity, enabling patients to develop personal relationships with staff over time.
- Physicians who do not embrace the organization's culture and philosophy, including PCC, are "counseled out."

Patient/Family Input into Program Design & Implementation

- The Haitian Advisory Council, a group of Haitian residents who meet with CHA leaders on a regular basis, advises CHA on how better to serve the Haitian community.
- Focus groups with patients and family members shaped new women's headache clinic, including: waiting area configuration, pain management, care coordination, inclusion of alternative care such as acupuncture and yoga, and clinic hours.
- Patient and family feedback was solicited in improving or planning cardiac care initiative, planned care program, HIV clinic, endocrinology services, and ICU care.

Measurement and Feedback

- CHA uses Press-Ganey[1] instrument to measure and guage patient satisfaction and provision of patient and family-centered care; problems identified are addressed promptly.
- There are ongoing efforts to solicit and respond to patient complaints.

Physical Environment, Technology, and other Structural Support

- Health center is built to optimize work flow, minimize congestion, and maximize privacy and "throughput."
- Electronic medical record/information system[2] helps to facilitate the development of shared care plans for patients with certain chronic diseases, including diabetes, asthma, and depression.
- An audio and computer-based depression screening tool allows patients to listen to questions in their native language, overcoming language and literacy barriers.
- "Authorware" multimedia software program educates patients with language or literacy barriers about diagnoses, self-care and newborn care, medical procedures; it helps prepares them for their interaction with providers.

[1] Press Ganey offers survey tools, reporting and consulting services to health care facilities to assist them in collecting and using patient evaluations in their quality improvement initiatives.
[2] CHA uses the Wisconsin-based Epic system.

Liberal use of Outside Resources

- CHA relies on PCC-related information from the Institute of Medicine (IOM), the Institute for Health Care Improvement (IHI) and the Institute for Patient- and Family-Centered Care (IPFC).

Flexibility

- Problems identified are addressed, procedures are modified.
- CHA has undergone numerous challenges in pursuing PCC. These include financial constraints and misaligned incentives, entrenched caregiver behavior, provider fatigue, and maintaining momentum. Yet CHA appears dedicated to continue to emphasize PCC across its many sites and departments, stressing that many small changes make a significant impact on the patient experience.

Background

Cambridge Health Alliance (CHA) is an academic public health care system and integrated delivery network that serves seven major communities north of Boston with a combined population of roughly 400,000. CHA operates three community hospitals, more than 20 community-based health centers and practices, a variety of community-based programs, and the Cambridge Public Health Department. CHA offers primary care, outpatient diagnostic and treatment services, medical and psychiatric emergency care, inpatient care (medicine, surgery, obstetrics, orthopedics, pediatrics, mental health and addictions, and sub-acute care), and preventive/health promotion services. CHA's hospitals handle roughly 17,500 inpatient admissions each year, along with approximately 520,000 ambulatory and 85,000 emergency department visits.

CHA is a regional safety net provider, providing 17 percent of all uninsured care in the state. CHA draws a diverse patient population from over 250 neighborhoods. Slightly less than half (45 to 50 percent) of all patients speak a language other than English as their primary language; approximately 40 languages are spoken frequently, including Portuguese, Spanish, Haitian Creole, Hindi, Bengali, Vietnamese, Russian, Chinese, Korean, and Arabic.

CHA was selected to be highlighted in this study because it was recommended by researchers and other experts as a leader in patient-centered care and cultural competence for underserved populations. Indeed, while CHA senior staff admit that the organization "has a long way to go," it was clear that the CHA has integrated PCC philosophy into both special initiatives and every day operations.

How CHA Practices Patient-Centered Care (PCC)

The leadership and staff at CHA have created an environment where PCC is practiced on a daily basis. Eight major elements make up the PCC experience at CHA.

Element #1: Welcoming, familiar environment

Feedback from patients suggests that seeking health care can be an intimidating and stressful experience, particularly when everything about a facility seems unfamiliar. Consistently and sincerely making patients feel welcome is viewed by CHA's leaders as a major opportunity to make a positive first impression, and to alleviate feelings of anxiety, vulnerability, and uncertainty. Examples of ways in which CHA creates this environment include the following:

- Most signs within the facility are written in the four major languages spoken by patients—English, Spanish, Portuguese, and Haitian-Creole.
- Artwork within many of the facilities is tailored to the cultures being served by the facility. CHA formed a committee to identify and purchase artwork by local artists that reflected the community.
- CHA staff, including patient interpreters, tend to go "way beyond the call of duty" when it comes to interacting with patients. Staff routinely walk patients who ask for directions to

their desired destinations rather than just pointing them in a certain direction or trying to give them verbal instructions that they may not easily understand due to language barriers.

- As discussed in more detail below, CHA hires staff that, to the extent possible, reflect the community being served. In addition, administrative and other staff often dress in ways that reflect their culture and heritage, thus signaling to patients that they are "like them." For example, one EEG technician at The Cambridge Hospital wraps her head in a turban-like style, as is quite common in the West Indies. Through word-of-mouth, her friendly, helpful nature has become well known among others in the community from Trinidad, Jamaica, Martinique and other West Indian nations. Those from her community often seek her assistance when they come to the hospital, even if they are not in need of an EEG.
- Staff members are encouraged to wear colorful buttons with a greeting written in the language that they speak. These buttons provide a visual cue to patients of staff members who speak their language.

Element #2: Respect for patients' values and expressed needs

CHA staff make a concerted effort to elicit, understand, and adhere to the values, preferences, and expressed needs of their patients. Virtually every conversation between provider and patient is structured to get patients to talk about their issues, priorities, and concerns. For example, at the Union Square Health Center, the first conversation with a new patient focuses almost exclusively on understanding his or her "context." Before discussing symptoms, health problems, diagnosis, or treatments, providers learn where the patient lives, who the patient lives with, who cares for them, who they care for, what they do for a living, etc. Several providers seek to draw a family tree so that they can understand the familial situation, and so that they will know something about other family members if they also seek care at the center. Because this clinic tends to treat multiple members of the same family, providers sometimes use a family medical record—i.e., a folder that contains the family tree and the individual medical records of various family members.

CHA has also developed programs and policies that demonstrate the organization's commitment to understanding and adhering to patient preferences and concerns. For example:

- Mothers-to-be who are not experiencing complicated pregnancies are given the opportunity to give birth in a home-like setting at CHA's birthing center, a Victorian-style building that feels much more like a home than a medical facility. The entire family can be in the room during the delivery (as is the custom in the cultures of many CHA patients).
- Family members are invited to stay with patients in the emergency room, even when they are "coding." If family members prefer to leave, they can sit on a bench that is right outside of the patient's curtained area, so that they can return at any time they want. (Prior to putting in the bench, busy ED workers would often forget to invite family members back in to see the patient after an emergency situation had passed.)
- CHA runs its EDs as "judgment-free zones." Many ED patients face serious economic and social problems, including poverty, domestic violence, and substance abuse, and they are judged harshly in other societal settings. But the staff in the ED are trained to accept them as

they are rather than to judge them and thus make the health care system another place where these individuals are made to feel ashamed of their circumstances.

Element #3: Patient empowerment

CHA makes a concerted effort to educate and inform patients so that they feel empowered to take charge of their own health and health care. Examples include the following:

- For patients who have certain chronic diseases (e.g., asthma, diabetes, depression), CHA has a "planned care" program that is designed to educate and empower patients to take charge of their own disease. These patients work together with their physicians to develop "shared care plans" in ambulatory practices. These plans allow the patient and provider to jointly develop realistic health goals, and then monitor progress toward them at each visit. For example, a patient with diabetes might jointly set goals with his or her doctor related to eating habits, physical activity, and blood glucose levels.
- CHA also sponsors a number of support groups and group visits that serve to empower patients with certain chronic diseases. In some cases these groups are tailored to a specific ethnic group. Group visits have been run for children with asthma, for patients with diabetes, and for pregnant women (including pre-natal classes and pre-natal yoga classes). These group gatherings have proven to be valuable learning experiences for patients, many of whom did not previously understand that many other individuals are facing the same problems. Group visits provide patients with opportunities not only to ask questions of providers, but also to learn from peers within and outside of their ethnic group.
- All educational materials are written at a fifth- or sixth-grade level and are, to the extent possible, available in the major languages spoken by CHA patients, including English and Spanish. In some cases it can be difficult to find materials written in Portuguese, Haitian-Creole, and other languages, although thanks to the wealth of materials on the Internet, these resources are becoming more widely available. In addition, videos and/or audio materials are increasingly being made available by CHA to help those who cannot read. For example, the new depression screening software is an audio-based system available in four languages, thus allowing many patients to listen to the survey questions in their native language in a private setting rather than having to read them.

Element #4: Socio-cultural competence

Many of CHA's staff come from the local community, and thus they understand and reflect the cultural, ethnic, and socioeconomic characteristics of the patients they serve. Perhaps the most visible manifestation of this socio-cultural competence is the fact that patients tend to face relatively few language barriers when they seek care at CHA. Many patients find that the registration staff, nursing staff, and even the physicians speak their language. For example, at the Union Square Health Center, the registration staff is all bilingual, with most speaking English and either Spanish or Portuguese (60 percent of the clinic's patients speak these two languages). Many of CHA's physicians are bilingual as well.

Of course even with a multicultural, largely bilingual staff, patients will inevitably run into situations where their providers do not speak their native language. To facilitate accurate and clear

two-way communication between patient and provider, CHA runs a large interpreter service, with interpretation available 24 hours a day in 40 languages. The service has grown tremendously over the years—it was launched with three interpreters 30 years ago after a housekeeper who was constantly being asked to interpret approached the hospital about becoming a full-time interpreter. Today the service has 40 full-time interpreters along with about 100 individuals available on an as-needed basis. In addition, CHA has contracts with a handful of companies that can provide interpretive services over the phone for patients. Roughly one-third of CHA's interpreters have graduated from the Cambridge College of Medical Interpreting, while most of the others have completed other interpretation training programs. Interpreters either come in person or are available by phone, depending on the situation and the language spoken. (Interestingly, patient surveys suggest that roughly half of patients prefer the greater privacy of over-the-phone interpretation, although there are times when visual contact is helpful in order to interpret body language and facial expressions.)

Interpreters go well beyond simple language translation to become "cultural translators" and "brokers" as well. In other words, interpreters make sure that each party understands how the other's culture may be affecting what they are saying and how they are interpreting each other. Finally, interpreters also serve as patient advocates. While initially this advocacy role was defined very broadly (e.g., to include helping them secure housing), this role has been evolved over time to focus on helping patients get what they need from the health care system, including applying for health coverage, making complaints, and dealing with providers who do not treat them appropriately.

New patients are always asked when they make appointments if they need an interpreter (so that one can be readily available when their appointment begins). Providers are also trained to recognize when an interpreter may be needed, even if the patient has not requested one. Interpreter services are accessed by dialing an easy-to-remember phone extension (3333). Interpreters are usually available within a few minutes—waits of more than 15 minutes or longer are generally considered unacceptable.

Along with interpreters, CHA's volunteer health advisors (VHAs) also help to provide culturally competent, patient-centered care as well. These community-based volunteers adapt care to patients' needs and help to educate patients and set appropriate patient expectations in a way that is consistent with their culture and literacy level. (See box below for more information on the VHA program.)

Element #5: Coordination and integration of care, including smooth transitions

CHA seeks to help patients who frequently use the health care system to navigate it more successfully. For example, CHA's planned care program seeks to improve the coordination and integration of care for patients who suffer from chronic diseases, including asthma, diabetes, and depression. Working through CHA's electronic information system, providers know which patients have these diseases and what tests they need. At the end of each visit, the system provides a post-visit summary that provides patients with a variety of information that helps them in coordinating their care, including a list of providers they saw, when they were seen, what diagnosis were made, what medications they are taking, and what referrals are being made to other providers.

The complete medication list is particularly helpful, since patients often have to provide this to other providers when they see them.

Nurses and in some cases physicians follow-up with patients after their visit to help them access other providers and to make sure that they are complying with their doctor's instructions (e.g., taking medications, changing eating and exercise habits, etc.). As discussed in greater detail below, VHAs also serve as vital support to patients who may have difficulty accessing the fragmented health care system. These advisors help to extend culturally competent care outside of CHA's walls by conducting follow-up with patients and helping with transportation. Going forward, VHAs will be getting more involved in helping patients navigate the system. For example, under a pilot initiative that is part of the Planned Care program, VHAs will be assigned to patients with chronic diseases to assist with scheduling follow-up care, arranging for transportation, and helping to overcome other barriers to care that face individuals with chronic illness.[3]

Element #6: Physical comfort and emotional support

CHA emphasizes physical comfort and emotional support, including the involvement of family and friends whenever possible. For example, as noted earlier, family members are encouraged to stay with patients throughout their stay in the Somerville Hospital ED (including when a patient is coding), and low-risk pregnant women are free to give birth in a physically comfortable, home-like setting that provides plenty of room for friends and family to be in the room during delivery.

Another example of promoting family support and involvement was the elimination of official "visiting hours" at the ICU. This allows and encourages families to visit at any time. Also, the Somerville Hospital ED created standing orders for pain and fever management that allows the triage nurse to provide a dosage of Motrin based on patient symptoms. This change resulted in a significant reduction in the time to administer medication.

Support groups and group visits have also proven to be an effective, popular way of providing emotional support, as these group settings bring together people (who may be of the same or different cultural backgrounds) who are experiencing similar medical and social problems. Successful groups have been run for pregnant women, Haitian patients with diabetes, and patients with asthma. Evaluation of the Haitian diabetes support group has found that it has been effective in helping patients to lower their blood glucose levels.

The provision of emotional support extends to situations where patients may not have family or friends available to them. For example, the women's health department launched a "doula" program where women who are otherwise socially isolated (as many immigrant women are, since family members may not be in this country) can have access to a doula—a trained layperson who is assigned to the pregnant women, and provides physical, emotional, and informational support. The doula, on call 24 hours per day, accompanies the woman on all prenatal visits and is also present during labor and delivery. The cost of the program is borne entirely by CHA (i.e., it is not reimbursed through Medicaid or private insurance).

[3] Planned Care involves the extension of elements of the Chronic Care Model to patients with a wide variety of illnesses and conditions. For more information, see the Institute for Healthcare Improvement: http://www.ihi.org/IHI/Topics/OfficePractices/PlannedCare/

Element #7: Easy access to care

Timely access to care is a critical component of PCC. Few things get a patient or family member more upset than being forced to endure long delays for care. For example, roughly 30 percent of customer complaints in the Somerville Hospital ED relate to delays in receiving treatment.

CHA uses a three-pronged approach to meeting patient demands for timely access to care. The first involves setting up systems to facilitate quick access to care. For example:

- The women's health clinic added evening hours to meet the needs of patients who work.
- The Somerville Hospital ED established a fast-track system to more quickly meet the needs of less urgent patients. At present patients seen in the fast-track are processed in 70 minutes (from arrival to discharge), compared to 81 minutes in the main ED. While both of these times are well below norms elsewhere in the state and nation, Somerville's medical director would like to reduce the fast-track turnaround time to 60 minutes or less.
- The Broadway Health Clinic staff are instructed to "squeeze in" teenage girls who come to the center for family planning services, including obtaining birth control pills. Staff have learned that these girls will not come back if they are asked to make an appointment or to return in two hours.
- The Broadway Health Clinic also offers "Open Access," whereby a certain portion of appointments are left open for walk-ins, same-day access or appointments within 72 hours.[4] This arrangement was implemented because the clinic learned that "that's what people want."

The second strategy involves setting appropriate expectations for how quickly care will be provided and keeping patients updated on a regular basis, especially if there is going to be a delay. For example, at the Somerville Hospital ED both the registration staff and the triage nurses regularly give patients a preview of what they can expect next and how long it will take to receive care. These staff are trained to be conservative when they give estimates about wait times and service times, as the goal is to make sure that the ED can meet or beat expectations. The ED's leadership spent a lot of time studying throughput and patient flow to help determine how long things typically take; these "standards" are provided to front-line staff so that they know how to estimate accurately. For example, staff know that a test for strep throat will take approximately 20 minutes, that blood work takes about two hours, and that a full workup will take a half day.

Third, CHA also enhances access by creating a "one-stop shopping" environment within a single site by including all services that patients are likely to need on a regular basis. Examples of this "one-stop shopping" approach include the following:

- Mental health specialists were brought onsite to work in the women's health department, thus helping to facilitate access to mental health services. Before these services were brought onsite, many patients who needed mental health assistance failed to get it, due to a variety of factors. First, there is a stigma associated with mental health problems in many cultures. Second, many CHA patients and their family members find it difficult to travel outside of their neighborhood for services; they lack transportation, and/or may be intimidated at the pros-

[4] As of summer 2005, the center has about 60% of appointments left open over a 5 week period. The goal is to have 70% of appointments open.

pects of leaving their neighborhood. In addition, many patients and family members hold the kind of jobs where they cannot afford to miss work, as one missed day could result in their being fired. Finally, without mental services being on site, many providers were also reluctant to raise the difficult issues involved (e.g., domestic violence, substance abuse, depression), as they believed there was little they could do to address these issues except to provide a referral to an outside specialist who the patient was unlikely to see.

- At the Union Square Health Center, patients can access nutrition services and mental health screening and treatment services. These services were added because it was discovered that many patients were not accessing needed nutrition and mental health services that were located off-site, sometimes at locations outside familiar neighborhoods.

Element #8: Community outreach

Consistent with its mission to improve the health status of the community, CHA runs an extensive community outreach program. These activities are overseen by the Joint Public Health Board (JPHB), a group of community leaders and consumers who are charged with monitoring community health indicators and gauging progress in meeting community health improvement goals. Through its Community Affairs Department, CHA has forged deep ties within the communities it serves by working in close partnership with local government, school systems, housing agencies, businesses, and other community-based and not-for-profit organizations. As a result, CHA has cultivated a whole cadre of community leaders who are willing to commit time and their organization's resources when a problem needs to be addressed.

The Community Affairs Department runs a variety of programs related to community outreach, including enrollment and case management; health promotion services; tobacco cessation programs; senior health programs; the volunteer health advisor (VHA) program; the zero disparities committee; multilingual interpreting, translation, and cultural competency training; HIV community services; family planning, women's and adolescent health; women, infant, and children's (WIC) program; and health care for the homeless.

Some of these programs, such as the VHA program and multilingual interpreting, are critical core elements of PCC at CHA. For example, VHAs help individual community members in accessing the health care system when they need it (see box below). As noted earlier, the multilingual in-

The Volunteer Health Advisor (VHA) Program

The VHA program consists of over 200 volunteers who each work an average of five to eight hours per month in the community. VHAs engage in a variety of activities, including: referring community members to CHA for services; providing basic one-on-one health education; giving health presentations for groups on various topics; conducting basic tests (e.g., blood pressure, glucose, cholesterol) at health screening events; running support groups for patients with diabetes; organizing health fairs; and providing peer supervision.

Volunteers are organized by language group and supervised by paid, bilingual/bicultural health educators and program coordinators. Each VHA receives 20 hours of training in four core sessions (empowerment and communication, presentation skills and techniques, public health, and outreach). In addition, CHA clinicians and/or representatives from community programs run monthly continuing education programs for VHAs.

A few VHAs have received additional training to become specialists in particular areas such as breast health, tuberculosis, HIV, and diabetes. These specialists help to run the support groups, which have been very successful. For example, a diabetes support group for Haitian patients has been shown to have a positive impact on blood glucose levels. Similar programs for Portuguese and Spanish-speaking patients began in the fall of 2004, with additional groups planned in the near future. Support groups are based on a standardized curriculum drawn from evidence-based standards. They are held at convenient locations, with transportation provided through taxi vouchers.

Since its inception in 2001, the VHA program has served over 9.000 people, including 8,100 screenings and more than 700 individuals who were signed up for health coverage and referred to a primary care doctor.

terpreting service provides patients who do not speak English with quick access (either in person or over the phone) with an individual who not only speaks their language, but who also understands their culture and how it affects their attitudes toward health and health care.

The other community outreach programs, while not necessarily core components of PCC, nevertheless operate using a patient-centered approach. For example, CHA's Health Care for the Homeless program emphasizes the importance of understanding the culture of homelessness as a critical component of the services it offers. Examination/treatment rooms in its two outreach clinics were intentionally designed to be large, since homeless individuals tend to have a lot of things with them (e.g., extra clothing and personal belongings) and also can be intimidated by small spaces. Staff members emphasize building a personal relationship with patients in order to earn their trust, since many homeless individuals value familiarity and tend to distrust strangers. In addition, staff are trained to initially focus their attention on treating whatever ailment the patient is complaining about, leaving until later—when trust has been established—any attempts to deal with the multitude of other health problems the homeless individual may be facing. Health Care for the Homeless staff also tend to travel with homeless patients to any provider visits that they arrange for their clients; their presence provides familiarity for the patient and also helps providers to better understand the patient's situation and actions.

Critical Structures and Processes that Allow CHA to Practice PCC

CHA could not deliver PCC on a consistent basis without leaders that are committed to doing so; a diverse culturally competent staff that has the right skills and training; patients and families who are intimately involved in the planning of patient-centered programs; measurement and feedback systems to gauge progress in providing PCC; and a physical environment and technologies that support the provision of PCC. What follows is a brief discussion of each of the key critical success factors that allow CHA to practice PCC on an everyday basis.

Factor #1: Passionate, committed leadership

CHA's mission is to improve the health of the community, and the organization's leadership takes that mission seriously. In virtually every communication with staff, CHA's former and current CEO have emphasized the organization's mission and its commitment to serving a diverse, multicultural customer base in a patient-centered way – i.e., through the provision of compassionate, supportive care that honors patients' cultures, values, preferences, and priorities. Leaders at the system and unit level consistently reiterate that it is unacceptable to *not* practice PCC. These messages have been loud and clear for many years, even in the early 1990s when the local community was much less heterogeneous than it is today. Indeed, leaders must "walk the walk" and not just "talk the talk." If staff senses any amount of hypocrisy, or any gap between what leaders say and do, the whole effort can become derailed.

CHA's leadership has also challenged the organization to improve by setting aggressive performance goals for the organization. For example, the CEO established an aggressive goal for boosting systemwide patient satisfaction scores. The goal for 2005 is to improve patient satisfaction scores and rankings across all CHA services and sites by 20 percent over 2004 levels. Com-

pensation systems for senior leaders are currently being revamped to create financial incentives for improvements in patient satisfaction scores.

CHA's leaders have also developed what are called "the alliance promises." These "promises" relate to four key areas of PCC, known as the "four I's"—introduce, inform, initiate, and interact. Each local unit is charged with developing specific promises in each area, along with concrete plans and goals that will ensure fulfillment of those promises.

Factor #2: Committees dedicated to PCC

CHA's leadership has formed several committees that are designed to keep leaders and the organization as a whole consistently focused on PCC. At the senior executive level, the Patient-Centeredness Steering Committee (PCSC) consists of approximately 20 people. It is co-chaired by the chief of medicine and the Senior Vice President of Performance Improvement, and also includes the COO, the vice president of organization development, the head of nursing, and nurse and physician leaders from each of the three hospitals. This committee meets monthly to review each site's Press-Ganey consumer satisfaction scores and other performance indicators (see measurement and feedback section for more details), share best practices in PCC, and provide assistance in implementing those practices.

In addition, there is a nursing council that consists of seven individual councils, one of which is the Patient/Family-Centeredness council. Launched in April 2005, this council includes approximately 15-20 nurse managers and nursing staff from each of the three hospitals; representatives come from both inpatient units and the emergency departments at the hospitals. The group is highly dedicated and very enthusiastic. It originally met once a month, but now meets every two weeks to share problems and best practices related to how to provide PCC and partner with patients in all interactions, and how to make sure that caregivers have the tools and supplies they need to practice PCC. (Initially the group was divided on whether to focus on providing PCC or supporting caregivers—but eventually concluded that both were important priorities.) The group is also in the process of making a family member a part of the council; this individual is currently working on a team that is trying to improve the provision of PCC within the ICU. This team was formed after a lack of communication between a provider and family members of a patient in the ICU led to a bad outcome.

Looking ahead, CHA plans to develop a formal patient/family advisory council that will provide input in four key areas:

- Identifying and developing processes and tools for educating the staff on PCC;
- Developing educational materials for patients and families;
- Improving operations and systems so that care can be more patient-centered; and
- Better managing data (e.g., patient satisfaction scores) that drives the measurement and improvement of PCC.

Factor #3: Staff recruitment and development

Delivering patient-centered care requires recruiting and developing the right type of staff. To the extent possible, that staff should reflect, appreciate, and celebrate the diversity of the communities and cultures that the organization services. CHA has succeeded in this regard. While not quite as diverse as the surrounding communities, the staff at CHA includes representatives from the vast majority of the cultures and communities it services. Just under 30 percent of CHA staff are non-whites, including 16 percent who are black, 8.5 percent who are Hispanic, and 4.6 percent who are Asian.

CHA takes step to ensure that applicants understand and are committed to a PCC approach before they are hired. Applicants receive detailed information on CHA's mission and community-based, patient-centered approach in brochures, interviews, and counseling, thus helping to ensure that those who come to CHA are committed to the type of practice required by CHA's leadership and demanded by patients, families, and the community at large.

CHA also invests heavily in training its staff to deliver PCC after they are hired. PCC is a formal part of the orientation program for each new employee. This orientation teaches new hires about what PCC is; how to partner, interact, and build relationships with patients; and how to resolve conflicts (e.g., dealing with difficult patients). To supplement this program, a new one-day stand-alone seminar is being developed that will be held for new and old employees. In addition, a variety of "mini workshops" on PCC are conducted on a regular basis during staff meetings. For example:

- One workshop focuses on the definition of PCC and why it is important. It includes an interactive session in which staff consider how their own experiences as patients or as family members of a patient can guide the way CHA provides care to patients and families.
- A separate mini-workshop has been developed to help managers focus staff on creating a welcoming environment for patients.
- Another workshop focuses on "service recovery"—that is, how to recover the trust and loyalty of a patient or family member who feels that service has been below standard. Drawing from research in the hotel industry, CHA has learned that soliciting and resolving customer complaints quickly can lead to very high satisfaction levels, even higher than among those who had no complaints. This workshop provides staff with tools for resolving patient complaints, including the "ALERT" approach, which emphasizes *active* listening, *letting* the person know you are sorry, *empathy, reacting* quickly to resolve the problem, and *telling* someone so the same things does not happen to another patient.
- Individual units also have their own training programs. For example, the Somerville Hospital emergency department held a two-day retreat on PCC for all ED providers and staff, including those providers that interact with the ED on a regular basis, such as laboratory, radiology, registration, security, and housekeeping staff. Due to the high cost and time-consuming nature of this program, however, it has not been repeated since 1998.

In addition to holding workshops and emphasizing PCC at staff meetings, senior leaders at CHA regularly communicate with staff on the importance of PCC and also provide helpful tips on how to provide it. For example, the medical director of the Somerville Hospital emergency department provides weekly tips to his staff on how to maintain service excellence.

Much of the training and ongoing communication centers on helping staff to understand and appreciate what the patient is experiencing when he or she attempts to access CHA for care. Specific techniques for achieving this goal include the following:

- Having staff think about a time when they or a close friend or relative needed inpatient care. Staff are encouraged to think about what was positive about the experience (and what staff did that made a real difference), as well as what was negative.
- Encouraging staff to think about what a patient's first impression might be when he or she comes onto the unit in which they work, and how their unit may be set up for the convenience of staff rather than the needs or preferences of patients. Staff are also encouraged to think about things that make them feel "less than totally proud" about their unit as well as things that might make them hesitant to bring a friend or family member as a patient. Finally, staff are taught to think about what could be done to "absolutely delight" patients and how the unit might be changed to make it attract attention from providers throughout the country.
- Staff are encouraged to "walk through" the unit as if they were a patient, beginning with first impressions as they walk or are wheeled through the entrance. They are encouraged to pay attention to both the physical and "psychological" aspects of all parts of care. This approach has been used liberally in several departments, including the Somerville ED where the medical director writes up and distributes personal impression from his walkthroughs.
- Staff are encouraged to think specifically about the experiences of patients whose primary language is not English, including the facilitators and barriers to good care that they face.

Training Medical Students: Integrated Clerkship

CHA trains third-year medical students, as well as physician residents, in its hospitals. Like all medical staff, these students and residents are indoctrinated into the PCC culture. In addition, CHA is in its second year of running an innovative pilot program for eight third-year medical students known as the Cambridge Integrated Clerkship program.

Under this program students do not experience the typical specialty-based rotations where they embark on a series of several-week rotations in various specialties. Rather, the students are assigned to particular patients whom they follow throughout the course of their treatment. Many of these patients are elderly and have multiple problems that necessitate care over a long period of time in a variety of settings. The students will, to the extent possible, follow these patients into these settings. Over time, the students not only get a tremendous clinical education in the various areas of specialty care that these patients require, they also they also get a deep understanding and appreciation for the patient and his or her preferences, values, and environment (e.g., support structure, living conditions).

The students who have completed the program thus far have described it as a life-altering experience that will forever shape how they think about patients and patient care. In addition, a mid-year comparison of students in the integrated clerkship to those in a traditional third-year placement found that students in the experimental program scored better than typical medical students on objective structured clinical examinations (OSCE) overall scores and scores in the area of communication, taking a history, conducting a physical exam, and giving oral presentations. The integrated clerkship is also being held at several other sites, including Brigham and Women's and Beth Israel/Children's Hospitals.

- Staff are encouraged to think about how best to provide emotional support to patients and families, including preventing and reducing levels of anxiety. They begin by thinking of a time when someone provided emotional support to them, and what specifically was helpful and not so helpful. They are also encouraged to think when they were successful in providing emotional support to a patient, as well as when they felt ineffective at doing so.

Finally, formal patient-centered "principles" and "ground rules" have been established within specific units to assist staff in consistently delivering PCC. For example, the peri-operative unit developed written principles that emphasize the importance of focusing on patients and families and their perceptions of care, including helping them overcome their fears and anxieties. Specific

ground rules include being on time (since delays increase anxiety); maintaining constant communication with patients (since information decreases anxiety); protecting privacy and maintaining confidentiality (e.g., by keeping doors closed, talking in a low voice, using the privacy screen on computers, etc.); keeping food and beverages out of the sight of NPO (nothing by mouth) patients; and taking responsibility for learning about the cultural differences of patients (e.g., how they like to be addressed, how they express pain, food preferences, norms for physical contact). Staff are also encouraged to take a formal self-assessment survey to evaluate how well these principles and ground rules are being followed.

Factor #4: Rewards and recognition

CHA has not historically tied compensation to meeting performance goals, including the delivery of PCC. But there is now a major push in that direction. In 2005 CHA implemented a new compensation scheme for senior leaders (including vice presidents and directors) that ties compensation to performance on 10 indicators, two of which relate to PCC (patient satisfaction, percent of patients willing to recommend CHA).[5] In addition, for staff physicians, roughly half of their salary increase each year is tied to incentives, one of which relates to their patient satisfaction scores. In the Somerville ED, each physician will be rewarded with a small monetary incentive if as a group the physicians meet a threshold score for patient satisfaction. According to the ED director, the threshold was set too high in the first year and no physicians received the incentive.

Going forward, CHA's leadership is committed to implementing a pay-for-performance system throughout the organization. The combination of measuring performance and tying compensation to that performance is thought to be a powerful way to get people's attention and to change behavior.

CHA also has a variety of programs to recognize employees who excel in service excellence and the provision of PCC. These include the "Promises Award," where one employee from each hospital campus and ambulatory site is recognized each month for providing outstanding service to patients. Winners receive a $50 gift certificate, a parking spot for one month, and a t-shirt; they are also recognized in written communications and have their photo put in display cases throughout the facility. Employees who receive special thanks from patients (either through a letter or a notation in a satisfaction survey) receive a thank-you card from CHA that includes a coupon for a free lunch. Employees are also encouraged to notice and appreciate good behavior from their co-workers by presenting them with certificates on a spontaneous basis. In addition, a variety of fun events are held throughout the year to celebrate service excellence successes, such as improving on Press-Ganey scores. Individuals and units that have had particularly noteworthy successes are invited by the CEO or other senior leaders to give a presentation on their programs, so that these practices can be celebrated and replicated throughout the organization.

Factor #5: Longevity and "counseling out"

All of CHA's efforts to find the right kinds of staff, provide them with training and other tools, and reward and recognize their performance has paid dividends with respect to longevity. In

[5] For most senior staff, these rewards relate to bonus; for others, it is part of overall assessment and salary increase.

fact, staff retention rates at CHA are higher than at many other institutions. For example, the nurse vacancy rate at CHA is 9.7 percent, compared to a national average of 13.6 percent, while the nurse turnover rate is 7.7 percent, compared to a national average of 14.6 percent. The net result of low vacancy rates and turnover is that staff tend to stay at CHA for a long time. For example, roughly 70 percent of the ED staff at Somerville Hospital has worked at the facility since 1998 or before. In other words, over the last seven years only 30 percent of the staff has turned over.

This longevity is helpful in certain ways to the provision of PCC, as it enables patients to develop personal relationships with staff over time. When patients call or come to CHA sites, they often seek out the people that they know, thinking of them as long-time friends rather than as healthcare providers. There are some disadvantages to longevity of staff, however, and this is discussed below.

While much of CHA's focus is on recruiting, training, and retaining good people, the organization will also not hesitate to "counsel out" physicians who do not embrace the organization's culture and philosophy, including PCC. (As discussed below, this is more difficult to apply to unionized staff including nurses.) For example, one surgeon who consistently displayed impatience and displeasure with having to spend so much time interacting with patients (e.g., to make sure they understood what was happening, to elicit their preferences and concerns) was asked to leave the organization. Another physician (an ED doctor) who was "miserably slow" and had low patient satisfaction scores was fired after repeated attempts to get him to provide better service.

Factor #6: Patient/family input into program design & implementation

CHA has only recently begun to make a concerted effort to get systematic, formal input from patients and families about the design and implementation of programs. However, this is clearly an area of emphasis going forward. In the past several years patients and families have been asked to provide input into a handful of discrete initiatives, as outlined below:

- After Press-Ganey scores revealed that Haitian patients were less satisfied with their care than were members of other ethnic groups, CHA set up a Haitian Advisory Council, a group of Haitian residents who meet with CHA leaders on a regular basis to advise them on how better to serve the Haitian community. This council has helped CHA to address some issues that were driving low satisfaction. For example, at the Somerville Hospital ED, Haitian patients tended to be very quiet and reserved, often saying very little during visits. When the medical director asked members of the Haitian Advisory Council about this behavior, they emphasized that many Haitians distrust the health care system, fearing that any information they provide to CHA would be used inappropriately (e.g., given to the government). After learning this, the ED director trained his staff to go out of their way to make sure that Haitian patients understand that CHA is "on their side" and that the information they provide is completely confidential and will not be shared with anyone else. The Haitian Advisory Council is also providing recommendations on how CHA's EPIC information system can be better tailored to meet the needs of the Haitian community.
- Patients provided informal guidance on room set-up, color scheme, and other aspects when the maternity unit was recently expanded.

- Focus groups were held with patients and family members to get their input into how to set up and run a new women's headache clinic. Input was sought on what "ideal" care would look like, including the configuration of the waiting area, how to ensure access to quick help when suffering acute pain, how to coordinate care—especially medications—inside and outside of CHA, whether and how to include alternative care such as acupuncture and yoga, whether the staff should be all women, and what the most convenient hours would be for the clinic.
- The cardiac care initiative at Somerville Hospital solicited opinions and ideas from patients and staff as a formal part of the planning process for that program.
- The steering committee for CHA's planned care program included chronically ill patients and their families.
- An advisory group of patients meets every month with CHA staff who are developing an HIV clinic.
- To gain input into how best to expand endocrinology services at Somerville Hospital, outbound phone calls were made by the vice president of organizational development to patients who recently had received such services. A similar approach will be used to get input into how to improve cardiac care intake at the hospital.
- As part of an effort to improve ICU care, interviews were conducted with family members of ICU patients to find out what was good and bad about their experiences. Both large and small issues were raised, including the problem of getting different, often conflicting information from nurses and physicians, and the lack of comfortable chairs in the waiting rooms.

Looking ahead, CHA is trying to replicate the Dana Farber Cancer Institute's approach to involving patients and family members. At Dana Farber, a patient/family member sits on virtually every important committee in the hospital, beginning with the board of directors. No major decision is made at Dana Farber with the considered guidance and advice of patients and families. CHA is already moving in that direction. As noted earlier, a family representative is being added to the nursing council that focuses on PCC, and CHA's nursing leadership is actively investigating how to set up a formal patient-family advisory council to provide input to CHA on critical issues related to patient care.

Factor #7: Measurement and feedback

CHA's leadership regularly tracks patient-centeredness as one of five categories of measures that are used to gauge performance. For the past five years CHA has been using Press-Ganey scores to measure various aspects of patient satisfaction and the organization's success in delivering patient- and family-centered care. The Press-Ganey survey is refined by CHA's Quality Management group based on specific CHA needs; in some cases, customized questions are added in order to gauge patient experiences with unique aspects of CHA services.

Scores are benchmarked against relevant peer groups. A high-level report is sent out monthly to each department, while a rolled-up quarterly report goes out to the board and senior leadership within CHA. This report highlights areas of strength and opportunities for improvement.

As noted earlier, CHA's PCSC meets monthly to review performance and progress against strategic goals. During these meetings, every chief reports his or her unit's results. Priority areas for improvement are identified, with managers developing 90-day action plans in conjunction with quality improvement specialists. Press-Ganey scores are also available on CHA's computer system at the unit level, where managers can access them and drill down to look at specific components of the data. Data are available by service, unit, and site. Individual units can choose what peer group they wish to be benchmarked against; for example, the Somerville Hospital emergency department measures itself against similarly sized EDs, all EDs in Massachusetts, and all hospital EDs nationwide.

CHA takes the feedback it gets from Press-Ganey scores/comments seriously, and frequently improvements are made quickly in areas identified as having problems. For example, after Press-Ganey scores indicated that Haitian patients were less satisfied than other groups with their patient care experience, CHA formed the Haitian Advisory Council, a group of Haitian patients and family members that meets regularly to discuss ways of serving this community better. Physicians and other clinical care staff from CHA attend these meetings regularly to hear what it is like to be a Haitian patient at CHA.

In addition to Press-Ganey scores, CHA regularly solicits informal feedback from patients and families that is designed to understand their experiences, perspectives, and preferences. For example:

- Panels have been held where patients whose primary language is not English have been asked what it is like to come to a hospital where people do not speak their language; how coming to that hospital is different from going to a hospital in their native land; whether they feel they are treated differently because they do not speak English; and what CHA could be doing better to serve them.
- Interviews with elderly patients have been regularly conducted, with their comments on a variety of issues being documented and reviewed. These interviews highlighted the importance of attentiveness, good bedside manners, and communication. They also highlighted how isolating and anxiety-producing an inpatient visit can be for the elderly.
- A short, three-question survey is administered to family members to gauge how effective hospital staff are in keeping them informed; how receptive staff has been to their questions and concerns; and their perceptions of how responsive the staff has been to their relative's (i.e., the patient's) needs.
- The phone system at Union Square Health Center was changed in response to patient complaints about its automated nature. Patients were afraid that providers were not getting their messages through the automated system, and as a result they would call back multiple times. Providers also complained about the difficulty of retrieving messages through the system. Now live operators are dedicated to answering the phones to take messages for providers. Messages are entered into the clinic's information system so that physicians and other providers can access them easily.

Finally, CHA also focuses on soliciting and responding to patient complaints, as the experiences of unhappy patients are viewed as one of the most valuable sources of learning and improvement. In fact, the medical director of the Somerville Hospital ED personally reviews every patient complaint and highlights/distributes the most important of these for discussion at staff meetings.

He spends far more time reviewing patient comments and complaints than he does reviewing performance on specific measures. Examples of changes that have been made in response to complaints include the following:

- After patients and family members complained about the lack of non-obstetrics-related reading material in the waiting rooms of the women's health department, staff began bringing in reading material from their homes.
- After complaints about the lack of evening hours, the women's health department added a second evening session each week staffed by two physicians. Additional staff were not needed, as resources were shifted from less busy periods during the day.

Factor #8: Physical environment, technology, and other structural support

The physical environment, technologic environment, and other structural supports help CHA to enhance the provision of PCC. In fact, the physical layout of various CHA facilities significantly improves access and timeliness of care. For example:

- CHA's Broadway Health Center was built based on the Institute for Healthcare Improvement's (IHI's) *Idealized Design of Clinical Office Practices* initiative to optimize the work flow and learn how to make the team work together to provide the best care to patients.[6] Under this model, which emphasizes access to care and rapid service for patients, the health center was set up in a U-shape, so that patients continually walk in one direction to move to their next service. This model serves to minimize congestion and maximize throughput.
- Each doctor in a clinic has two examination rooms: one patient can be "prepped" by a nurse (e.g., having vital signs taken) at the same time that another is being seen by the doctor. Once the physician finishes with a patient, he or she can move to the next room where the patient is now ready to be seen; at this point, the nurse can then call in the next patient and begin his or her preparation.
- "Teen" rooms are placed at one end of the clinic, away from where other adolescents and children are treated; this provides teenage girls who come in for gynecologic visits with privacy.
- Scales are placed in private rooms rather than in the hallway of the clinic so as to ensure privacy.
- A bench right is placed outside the patient's treatment area in the ED so that family members can easily come and go as they please from the treatment area. Prior to installing these benches, family members who chose to leave the area went to the waiting room, where they were often forgotten by harried medical staff.

CHA also continues to invest in technologies that help to support the provision of PCC. As noted, the electronic medical record/information system[7] helps to facilitate the development of shared

[6] For more information see the Institute for Healthcare Improvement: http://www.ihi.org/IHI/Programs/ConferencesAndTraining/Calls+to+Action+Idealized+Design+of+Clinical+Office+Practice.htm

[7] CHA uses the Wisconsin-based Epic system.

care plans for patients with certain chronic diseases, including diabetes, asthma, and depression. In addition, CHA has developed an audio and computer-based depression screening tool that allows patients to listen to questions in their native language (the audio is available in the four most common languages spoken by CHA patients—English, Spanish, Portuguese, and Haitian-Creole). This technology provides privacy (which is important when it comes to asking about mental health issues) and helps overcome language and literacy issues.

CHA is also implementing Authorware, a multimedia software program that delivers health information in different languages to patients with low literacy skills. The software can be used in the inpatient, ambulatory, and community setting. It helps to enhance and make clinical teaching time more effective by preparing patients to interact with clinical staff prior to their visit. The system helps to reduce staff and medical interpreter time for repetitive, standardized teaching and assessments. It also systematically tests and documents patient comprehension, thus ensuring that patients understand the messages they are receiving. CHA is using Authorware for three purposes:

- To educate patients about diagnosis and self-care practices in tuberculosis, diabetes, breast health, and care for new mothers and newborns.
- To educate patients about procedures, such as a mammography, breast biopsies, and breast ultrasound.
- To help assess/screen patients for certain conditions, including diabetes, depression, and mental and physical function.

Factor #9: Liberal use of outside resources

CHA relies heavily on outside resources such as the Institute of Medicine (IOM), the Institute for Health Care Improvement (IHI) and the Institute for Patient- and Family-Centered Care (IPFC). The IOM's *Crossing the Quality Chasm* report—which highlighted patient-centeredness as a key element of quality—helped to clarify in the minds of CHA's leaders the need to measure performance on indicators that gauge the degree to which care is patient-centered. Several years ago a visit to IPFC convinced CHA leaders of the need to involve families and patients more in the planning and design of programs, something that had not historically been done within the organization in any systematic manner. Managers have also attended IHI's "train-the-trainer" conferences where they learned about how to organize efforts to improve service and the provision of PCC. As noted previously, the Broadway Health Center was redesigned based on an IHI model. And much of the PCC is based on the adoption of the Chronic Care Model.

Factor #10: Flexibility

At CHA, flexibility is critical to delivering PCC. This means that the organization must constantly be reviewing its procedures and adapting them as needed. When a problem arises, CHA and unit leaders will not wait a year for definitive evidence to come in documenting the problem. Rather, they will discuss and take steps to resolve the issue at the next staff meeting.

Challenges

Despite its successes in integrating PCC across the organization, CHA has faced and continues to face some real challenges in providing PCC.

Challenge #1: Financial constraints and misaligned incentives

Like most health care organizations, and especially safety net institutions, CHA faces financial constraints that limit any "extra" expenditures. Training and management of VHAs and doulas requires investments that are not reimbursed by Medicaid or other forms of insurance. Also, measuring indicators of PCC, such as follow-up telephone calls to discharged patients, can be expensive. Yet without research and evaluation, an organization can not monitor and improve its PCC "performance," and certainly can not demonstrate the link between PCC and outcomes or even "process" measures. Under leadership that is dedicated to PCC, CHA has been able to make PCC-related investments, but there is a constant need to juggle priorities.

Another challenge is related to CHA-specific incentives. Unlike many organizations that serve the uninsured around the country, CHA is fortunate to receive reimbursement for the vast majority of the patients it sees; roughly 95 percent of patients qualify for some form of reimbursement, including Massachusetts' Uncompensated Care Pool (also called the "free care" program), which provides organizations with payment for caring for the poor who lack health insurance.[8] Payments, however, are tied to the provision of acute services, including inpatient admissions and emergency room visits. Thus, to the extent that CHA is successful through PCC-related outreach and prevention in keeping patients out of the hospital, the organization suffers financially.

Challenge #2: Changing caregiver behavior

While the vast majority of physicians and other health professionals at CHA wholeheartedly embrace the notion of PCC, some of them remain confused about PCC because it is so different than what they were taught during their training. This is particularly challenging when it comes to long-time employees (of which there are many at CHA) who may have been trained in a different era when the needs of medical professionals, not patients, were thought of as being paramount.

Interestingly, it appears to be more challenging to change the behavior of the non-physician staff—the vast majority of whom enjoy tremendous job security thanks to their unions—than to change the behavior of physicians, most of whom are CHA employees who do not enjoy any union protections. Overcoming this challenge is a matter of perseverance; in every communication, staff meeting, and training seminar, the leaders of CHA constantly reiterate the need to embrace and deliver PCC during every encounter with patients, and they constantly work to provide the tools and training that caregivers need in order to do so.

[8] The free-care program is financed through a combination of tax revenue from individuals and funding from hospitals and health plans. It is designed for individuals with annual incomes too high to qualify for Medicaid but who cannot afford private health insurance. More than 480,000 people received medical care through the program in 2004, at a cost of $580 million to the state.

Challenge #3: Overcoming fatigue, maintaining momentum

CHA has been pushing the notion of PCC for more than a decade. While tremendous progress has been made, more work needs to be done. While the organization is constantly striving to improve, it can become challenging for individuals and for the organization as a whole to keep the momentum going. Getting very busy nurses and physicians to take the time to attend staff development sessions, and to focus on teams and PCC strategies is a challenge. Without constant encouragement and determination from the system and unit leadership, the effort could easily stall. To help keep the momentum going on a sustained basis, CHA's leaders are actively working to develop an incentive-based compensation system that is tied to performance in key areas, including PCC.

Conclusion

While CHA has implemented multiple programs that emphasize PCC across its many sites and departments, it has also learned that "the whole is more than the sum of its parts." CHA leaders stressed that many small changes can add up to a huge change in the patient experience. From a friendly, welcoming greeting and the ability to speak in one's native language, to computer printouts summarizing one's medication and personalized care plan, CHA presents numerous "best practices" that can be replicated in other health care organizations under the right leadership and drive.